Division of Developmental Disabilities

Office of Health Care

Health Care Guidelines
and
Nursing Clinical Standards

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DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS
DIVISION OF DEVELOPMENTAL DISABILITIES

HEALTH CARE GUIDELINES

INTRODUCTION

The Division of Developmental Disabilities has the responsibility to ensure the basic health and safety of people with developmental disabilities who are receiving services and supports within the developmental disabilities system. The Health Care Guidelines described herein are the minimum standards of care agencies are expected to adhere to in the provision of day and residential supports and services.

Included within the Guidelines are Nursing Clinical Standards that are based on the Rhode Island Nurse Practice Act, nationally accepted clinical standards for nurses in the field of developmental disabilities, as well as best practices in nursing identified in the research for the development of this document. These clinical standards provide the framework for the provision of nursing services in the developmental disabilities system, while also allowing for flexibility in accordance with agency specific policies and procedures.

These Guidelines do not address all possible medical conditions as it is understood that medical circumstances will vary for each person. The level of a person's health care needs will be identified through the information gathered during the completion of his/her health care screening assessment and annual health care needs profile, as specified in agency policy and consistent with any pertinent guidelines outlined herein.

DEFINITIONS:

PROFESSIONAL NURSING:

Professional Nursing is practiced by Registered Nurses (R.N.'s). The practice of professional nursing is a dynamic process of assessment of an individual's health status, identification of health care needs, determination of health care goals with the individual and/or family participation, and the development of a plan of nursing care to achieve these goals. Nursing actions, including teaching and counseling, are directed toward the promotion, maintenance, and restoration of health and evaluation of the individual's response to nursing actions and the medical regimen of care. The Professional Nurse provides care and support of individuals and families during periods of wellness and injury, as well as incorporating where appropriate, the medical plan of care as prescribed by a duly licensed physician, dentist or podiatrist or other licensed health care providers authorized by law to prescribe. Each R.N. is directly accountable and responsible to the individual for the nursing care rendered (Rhode Island General Law Chapter 5-34).[1]

PRACTICAL NURSING:

Practical Nursing is practiced by Licensed Practical Nurses (L.P.N.'s). It is an integral part of nursing based on a knowledge and skill level commensurate with education. It includes promotion, maintenance, and restoration of health and utilizes standardized procedures leading to predictable outcomes which are in accord with the professional nurse regimen under the direction of a professional nurse. In situations where professional nurses are not employed, the licensed practical nurse functions under the direction of a duly licensed physician, dentist, or podiatrist. Each L.P.N. is responsible for the nursing care rendered (Rhode Island General Law Chapter 5-34).[1]

SUPPORT STAFF:

Trained, responsible individuals other than the licensed nurse who may function in a complimentary or assistive role to the licensed nurse in providing direct care to a person with developmental disabilities.

[1] Professional Nursing and Practical Nursing as defined in the Rhode Island Nurse Practice Act, Chapter 5-34 of the R.I. General Laws, as amended, entitled "Nurses" (*Appendix A*).

NURSING PROCESS:

Nursing intervention takes place within the context of the nursing process. The nursing process is comprised of the following essential elements: assessment/data collection; nursing diagnosis; planning; intervention; and evaluation.

ASSESSMENT/DATA COLLECTION:

The Professional Nurse (R.N.) will conduct a nursing assessment which includes a deliberate and systematic collection of data to determine a person's current health status; including physical assessment, data analyses, problem identification, and development of a plan of care. The R.N. will complete a nursing assessment at a minimum of annually; whenever there is a change in a person's health status; or, as determined by the R.N. based on the person's health care needs.

NURSING DIAGNOSIS:

Nursing diagnoses are concise statements of conclusions derived from assessment data collected and include the presenting medical diagnoses and the person's unique nursing and health care needs. Nursing diagnoses are recorded in a manner that facilitates the nursing process.

PLANNING:

The Professional Nurse (R.N.) will develop a nursing plan of care based upon the data obtained during the assessment. The elements of the plan of care will reflect data obtained as part of the person's initial health care screen as well as subsequent assessments, and shall be congruent with the person's unique health care needs. The plan of care provides guidance for support staff in the provision of health care activities that may be delegated pursuant to the Nursing Clinical Standards outlined herein (*Section NCS 1*). Nursing plans of care are recorded, communicated to others, and revised as necessary according to the agency's written policy and procedure.

INTERVENTION:

The Professional Nurse (R.N.) will intervene as guided by the nursing plan of care to implement nursing actions that promote, maintain, or restore wellness and prevent illness. The R.N. shall ensure the implementation of the plan of care and may delegate all or portions of the implementation to the Licensed Practical Nurse (L.P.N.) or to appropriately trained support staff according to the Nursing Clinical Standards outlined herein (*Section NCS 1*). The L.P.N. may assist in the delegation process under the direction of the R.N. It is recognized that when the L.P.N. works in a team relationship with the R.N., the L.P.N. contributes significantly to each aspect of the nursing process. However, final responsibility for the nursing process and it's application remains with the R.N.

EVALUATION:

The Professional Nurse (R.N.) will evaluate and document the person's response to the interventions outlined in the plan of care; revise the plan as necessary; and, identify the degree to which the expected outcomes have been achieved.

CONTROLLED SUBSTANCE:

Controlled substance means a drug, substance or immediate precursor in Schedules I - V of Chapter 21-28 of the Rhode Island General Laws, as amended (*Appendix B - Controlled Medication Formulary)*.

DELEGATION:

Delegation by a Professional Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) means transferring to a competent, appropriately trained individual, the authority to perform a specific nursing task in a specific situation. While tasks and procedures may be delegated, the nursing functions of assessment/data collection; nursing diagnosis; planning; intervention; and evaluation may not be delegated. The nurse retains the responsibility and accountability for the delegated task.

LEGEND DRUG:

Legend drug means any drug so designated pursuant to the provisions of Section 21-31-15 (k)(c)(3) of the Rhode Island General Laws, as amended, and said drug is labeled: "Caution: Federal Law Prohibits Dispensing Without a Prescription" (*Appendix E)*.

LICENSED HEALTH CARE PROVIDER:

In reference to the Health Care Guidelines and Nursing Clinical Standards outlined herein, a licensed health care provider shall include: a duly licensed physician, dentist, certified registered nurse practitioner, podiatrist, or other licensed health care providers authorized by law to prescribe.

MEDICATION ERRORS:

Incidents involving medications which may or may not cause harm, directly or indirectly to a person's health and welfare. By way of example, and not in limitation, medication errors include:

a) omission of a dosage(s) or failure to administer;
b) incorrect dosage(s);
c) incorrect medication(s);
d) medication(s) given by incorrect administration route;
e) medication(s) given at the incorrect time;
f) medication(s) given to the wrong person;
g) any inappropriate use of medications;
h) failure to follow agency procedures for medication administration; and,
i) medication or treatment given without an order from a physician or other licensed health care provider.

SUPERVISION:

The Professional Nurse (R.N.) shall supervise the performance of the delegated nursing task in accordance with the requirements of supervision. These shall include, but not be limited to, initial direction, periodic evaluation of staff performance, and periodic evaluation of the degree to which the expected outcomes have been achieved.

DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS
DIVISION OF DEVELOPMENTAL DISABILITIES

HEALTH CARE GUIDELINES[2]

HCG 1 Agencies shall maintain written health care and nursing policies and procedures, that at minimum address all areas indicated and outlined in the DDD Health Care Guidelines and Nursing Clinical Standards, including a policy for the agency's nursing support protocols for evening, weekend, and holiday coverage. Such policies and procedures shall be available upon request to the Office of the Executive Director/DDD for review and approval.

HCG 2 A current emergency fact sheet or other form shall be accessible and available in the agency files and any other relevant location as identified in the agency's policy and procedure. Information required includes, but is not limited to:

a) the person's name, address, telephone number and date of birth;
b) Social Security number;
c) Medicaid number, Medicare number, and/or other insurance information;
d) guardian and/or next of kin's name and telephone number;
e) name and telephone number of the primary care physician, and other relevant health care providers/specialists;
f) medical diagnosis;
g) date of last annual physical;
h) Tetanus, TB, and Hepatitis B immunization status;
i) list of current medications and dosages; and,
j) list of any known allergies.

HCG 3 Incident reports are maintained on serious incidents in accordance with the Office of Quality Assurance/DDD reporting requirements, as defined in the MHRH Licensing Regulations. Examples of these include, but are not limited to:

a) an injury that requires medical care or treatment beyond routine first aid;
b) serious or repeated medication errors;
c) neglect; and,
d) death.

[2] Asterisk * denotes Guidelines relevant within the scope of residential supports and services, and would not necessarily fall within the purview of day support programs.

HCG 4 Influenza, pneumococcal, and other adult vaccination policies and protocols shall be developed and implemented by the agency in accordance with the most current recommendations of The Advisory Council on Immunization Practices (ACIP) Guidelines (*Appendix C*) for these vaccinations, and as recommended and ordered by the person's physician or other licensed health care provider.

a) Influenza Vaccination:
Annual vaccination as recommended and ordered by the person's physician or other licensed health care provider.

b) Pneumococcal Vaccination:
Persons age 65 and older, if not previously vaccinated, and other "at risk" individuals as recommended and ordered by the person's physician or other licensed health care provider.

c) Immunization records are maintained with up to date Tetanus (every 10 years), PPD, and Measles/Mumps/Rubella (MMR date of immunization for anyone born after 1957, where record is available).

d) Hepatitis B vaccine and antibody testing must be offered, in accordance with accepted primary care guidelines to all people receiving residential supports. Documentation of hepatitis status or date of vaccination must be present in the person's medical record. The agency must also document that agency staff receive training in universal precautions for infectious diseases.

HCG 5* A record of menses is kept for women if determined as needed by the person's physician or other licensed health care provider. If the person has an existing medical condition and is on medications which warrant close monitoring of menses, then records are also maintained.

HCG 6* A record of monthly weights is kept if determined as needed by the person's physician or other licensed health care provider. If medications or treatments which require close monitoring of weight are prescribed, then records are also maintained.

HCG 7 Any physician, nutritionist, or other licensed health care provider's prescribed diet order is implemented and a copy of the diet is in the person's medical record.

HCG 8 A physical examination is obtained annually. At minimum, components of the physical exam shall include completion of accepted primary care screening guidelines for pap smears, mammography, prostate screening, and colon screening (if routine screening is deferred by the person's physician or other licensed health care provider, documentation as to the reason for the deferral must be included in the person's medical record). A copy of the physical exam report or documentation including the physician or other licensed health care provider's name, date of physical examination, and recommendations shall be included in the person's medical record.

HCG 9* Dental examinations and cleanings are performed as recommended by the American Dental Association (if routine screening and/or cleanings are deferred by the person's dentist, documentation as to the reason for the deferral must be included in the person's medical record). A copy of the exam report or documentation including the dentist's name, date of exam and recommendations shall be included in the person's medical record.

HCG 10* Vision and audiological examinations are performed if indicated as a need by an initial screening and the results of the screening are included in the person's medical record. The need for subsequent examinations is to be determined by the health care provider. Glasses and hearing aids are provided as prescribed and kept in good repair. The person receives support to use the glasses and hearing aids as prescribed.

HCG 11* An initial orthopedic and physical therapy evaluation for people with mobility issues is obtained, with subsequent examinations to be determined by the health care provider. Documentation of a comprehensive PT and/or OT program to ensure maximum level of mobility is included where indicated by the person's physician or other licensed health care provider.

HCG 12 A seizure record is maintained in which the date, antecedent, duration, type of seizure and post-seizure status is recorded. Blood levels of seizure medications are obtained as determined by the person's physician. Lab results are recorded and maintained in the person's medical record.

HCG 13 Adaptive equipment (e.g., wheelchairs, braces, communication device) is obtained as needed and kept in good repair. Regular assessment for proper fit and usage is also completed.

HCG 14 Oxygen (O_2) Therapy Guidelines

14.1 O_2 shall be administered according to orders written by the person's physician or other licensed health care provider. The order shall include, at minimum**,** the parameters for utilization of O_2 therapy.

14.2 Agencies shall have a written policy and procedure for PRN O_2 orders which include, at minimum, protocols for notification of the agency nurse and emergency protocols for acute respiratory distress.

14.3 O_2 therapy in any residential and/or day program setting, shall be administered through the utilization of an oxygen concentrator.

14.4 During the course of transportation, and in community activities outside of the agency setting, O_2 therapy may be delivered through the utilization of E cylinders which are appropriately secured in a portable transport system.

14.5 Agencies are required by law to maintain one E cylinder oxygen tank for each person receiving O_2 as a back-up in the event of a power failure (the E cylinder must be available even in a home or day site with generator capacity).

14.6 If there is a need to store additional cylinders due to the nature of the O_2 requirements for any individual, a request must be submitted to the Office of Health Care/DDD documenting the following information:

a) the person's medical condition for which O_2 is required;
b) the physician's O_2 orders;
c) the proposed number of tanks to be stored; and,
d) a description of the physical location in which the tanks will be stored.

Decisions relative to increased tank storage will be made on a case by case basis after review of the request and documentation.

14.7 E cylinders shall be stored in an appropriate location in a fixed stand or secured to a fixed object and away from direct heat sources. E cylinders shall not be stored in the person's bedroom or any communal areas within the home. E cylinders maintained in day program sites shall not be stored in communal areas. Any storage of O_2 must meet the requirements of the National Fire Protection Association's protocols for O_2 storage (*Appendix D*).

14.8 In extraordinary circumstances in which the person's need for an O_2 flow rate is greater than the capacity that an oxygen concentrator can deliver, the agency may request a variance from the Division of Developmental Disabilities to utilize E cylinders or another form of O_2 delivery within the residential/day sites. Such variance request must be made in writing to the Office of the Executive Director/DDD and include documentation of the person's medical status and O_2 orders.

In the event the variance is granted, any storage of O_2 must meet the requirements of the National Fire Protection Association's protocols for O_2 storage.

HCG 15 Medication Administration and Treatment Guidelines

15.1 Medications and treatments shall be stored safely, securely and properly, following manufacturer's recommendations and the agency's written policy.

15.1.1 The dispensing pharmacy dispenses medications in containers that meet legal requirements. Medications shall be kept stored in those containers. An exemption from storage in original containers is permitted if using a pre-poured packaging distribution system (e.g., medi-set).

15.1.2 A corrected label, corresponding to the medication administration sheet, shall be completed for any medication change orders.

15.2 Medications shall only be administered by support staff who have
- a) received documented training in medication administration;
- b) have displayed appropriate competencies to carry out said procedure: and,
- c) to whom the procedure has been delegated by a Registered Nurse or Licensed Practical Nurse according to the Nursing Clinical Standards outlined herein (*Section NCS 1*).

15.3 Medication sheets shall be maintained by the agency for all persons who do not self-administer their medications. Medication sheets will include, at a minimum:
- a) name of the person to whom the medication is being administered;
- b) clear record of the medication(s) name;
- c) dosage;
- d) frequency;
- e) route of administration;
- f) date of administration;
- g) time of administration;
- h) any known medication allergies or other undesirable reaction;
- i) any special consideration in taking the medication, e.g., with food, before meals, etc.; and,
- j) the initials of the person(s) administering the medication.

15.4 The medication record shall have a signature sheet of all staff authorized to administer medications, which includes the staff person's full name, signature, and the initials he/she will be using on the medication sheet.

15.5 The agency shall have a written policy and procedure describing medication safeguards and support protocols for people who self-administer their medications.

15.6 Storage of medications shall comply with the following requirements:

a) medications shall be stored in a locked area;
b) medications shall be stored separately from non-medical items;
c) medications shall be stored under proper conditions of temperature, light, humidity, and ventilation;
d) medications requiring refrigeration shall be stored in a locked and secured container within the refrigerator; and,
e) internal and external medications shall be stored separately**.**

15.7 Potentially harmful substances (e.g., urine test reagent tablets, cleaning supplies, disinfectants) shall be clearly labeled and stored in an area separate and apart from medications.

15.8 If medication errors or omissions occur, the nature of the error or reason for the omission shall be documented according to the agency's written policy and procedure.

15.9 All prescriptions shall be reviewed and renewed annually at the time of the annual physical or as indicated by a physician or other licensed health care provider. Any and all medication changes require a new prescription.

15.10 PRN medications are specifically prescribed by a physician or other licensed health care provider and include specific parameters and rationale for use.

15.11 All PRN medications shall be documented on medication administration sheets. The documentation shall include:

a) the name of the person to whom the medication is being administered;
b) the name, dosage, and route of the medication;
c) the date, time(s) and reason for administration;
d) the effect of the medication; and,
e) the initials of the person(s) administering the medication.

15.12 The name and dosages of PRN medications administered for the purpose of behavioral intervention must be documented according to the written policy and procedures of the agency, and as part of an approved plan in accordance with the MHRH Licensing Regulations (*Section III - Regulations for Behavioral Interventions*). At minimum, the documentation shall include a description of the behavior(s) as well as a description of less intrusive interventions that were implemented prior to administering the medication. Documentation of follow-up by nursing staff/supervisory staff should also be noted.

15.13 Medication checks for anyone taking psychoactive medications will include direct contact on a regular basis between the person for whom the medications are prescribed and the physician, psychiatrist, or other licensed health care provider. The effectiveness of the medication must be assessed on a regular basis by the multi-disciplinary clinical team.

Tardive dyskinesia checks will be performed on a regular basis by a nurse using a standard instrument, a physician or other licensed health care provider, and documented in the person's medical record.

15.14 Monitoring of Controlled Medications: Medications listed in Schedules II, III, IV, and V (*Appendix B - Controlled Medication Formulary)* and dispensed by the pharmacy shall be appropriately stored, documented, and accurately reconciled:

15.14.1 Schedule II medications shall be stored separately from other medications in a double locked drawer or compartment, or in a separate storage location which is locked, has additional security restrictions, e.g., combination lock, and has been designated solely for that purpose.

15.14.2 A controlled medication accountability record shall be completed when receiving a Schedule II, III, IV, or V medication. The following information shall be included
a) name of the person for whom the medication is prescribed;
b) name, dosage, and route of medication;
c) dispensing pharmacy;
d) date received from pharmacy;
e) quantity received;
f) name of person receiving delivery of the medication; and
g) expiration date.

15.14.3 Any and all controlled medications shall be counted and signed for at the end of each shift, or in accordance with the agency's written policy and procedure.

15.14.4 In independent living arrangements, the staff person shall comply with the agency's written policy and procedure for reconciliation of controlled medications.

15.14.5 The agency shall maintain signed controlled medication accountability records for all persons receiving such medications.

15.15 Administration of Controlled Medications: When a controlled medication is administered, the person administering the medication shall immediately verify and/or enter all of the following information on the accountability record and the medication sheet:

a) name of the person to whom the medication is being administered;
b) name of the medication, dosage, and route of administration;
c) amount used;
d) amount remaining;
e) date and time of administration;
f) signature of the person administering the medication; and,
g) expiration date.

15.16 Disposal of Medications

15.16.1 Disposal of Controlled Substances: Agencies shall have a written policy and procedure for the disposal of damaged, excess and/or expired controlled substances. The policy and procedure shall outline the agency's protocol for the inventory and disposal of all such controlled medications in accordance with federal Drug Enforcement Administration (DEA) regulations and all other applicable federal, state, and local regulations (*Appendix E*).

15.16.2 Disposal of All Other Legend Drugs (Non-controlled Substances): Agencies shall have a written policy and procedure for the disposal of all non-controlled medications. The policy and procedure shall conform to the requirements outlined in the Department of Health's *"Rules and Regulations Governing the Disposal of Legend Drugs"* (*Appendix F*).

HCG 16 Support Staff In-Service Training Guidelines

16.1 Agencies shall have written policies and procedures for ongoing health care in-service training for all support staff. Specific health care related in-service training shall be conducted or supervised by a nurse or a qualified instructor as specified in the agency's policies. Nursing staff shall delegate tasks only to support staff who have received training commensurate with the agency's protocols and have demonstrated competencies in each area of training. Support staff shall be considered competent upon documentation of satisfactory completion of each training module. Satisfactory completion and documentation of training shall include demonstration as well as knowledge of the delegated task.

A baseline competency training checklist (*Appendix G*) shall be completed prior to the delegation of any nursing tasks, including medication administration. The intent of the competency checklist is to ensure for the delegating nurse that the staff person has satisfactorily completed all required elements of the in-service program and has satisfactorily demonstrated skills and competencies in the designated areas.

16.2 At minimum, support staff shall receive in-service training in the following nursing/health care/health and life education areas:

1. Adaptive Equipment, if applicable
2. Basic First Aid
3. Basic Health Care Treatments
4. Cardio-Pulmonary Resuscitation
5. Communicable Diseases/Infection Control/Standard Precautions/Exposure Control Plan (OSHA)
6. Medication Administration
7. Nursing/Health Care Plan
8. Nursing/Health Care Policies and Procedures
9. Nutrition/Food Handling
10. O_2 Therapy, if applicable
11. Personal Hygiene
12. Procedures for Care and Suctioning of Tracheostomies, if applicable
13. Procedures for G Tube Feedings, if applicable
14. Seizure Precautions
15. Sexuality Training
16. Signs and Symptoms of Illness

16.3 All nursing staff and support staff shall successfully complete an approved course (e.g., Red Cross or Heart Association curriculum) in CPR and foreign body airway obstruction. Documentation of course completion shall be maintained in the individual's personnel file.

HCG 17 Variances to Health Care Guidelines/Nursing Clinical Standards Requirements

Variances to requirements of the Health Care Guidelines and Nursing Clinical Standards may be made with the documented approval of a physician or other licensed health care provider. Requests for variances and the relevant documentation shall be submitted in writing to the Office of the Executive Director/DDD. Such requests and documentation shall also be maintained in the person's medical record.

NURSING CLINICAL STANDARDS

NCS 1 NURSING CLINICAL STANDARDS FOR DELEGATION OF NURSING TASKS

1.1 The Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) delegating the task(s) is responsible and accountable for the nursing care provided to the person with developmental disabilities. The R.N. retains accountability for appropriate nursing delegation decisions, supervision, and the coordination of care.

1.2 The final decision as to which nursing task(s) can be safely delegated to support staff is determined by the R.N. on a case-by-case basis pursuant to her/his own professional judgement.

The following aspects of the nursing process shall be performed only by a Registered Nurse:

a) performance of a full physical assessment;
b) validation of the assessment data;
c) formulation of the nursing diagnosis and plan of care/health service plan for the person with developmental disabilities;
d) determination of the appropriate nursing interventions derived from the nursing diagnosis; and,
e) evaluation and documentation of the person's response to the interventions outlined in the plan of care; revision of the plan as necessary; and, identification of the degree to which the expected outcomes have been achieved.

1.3 The Professional Nurse (R.N.) must make an assessment of the person's nursing care needs prior to delegating a nursing task.

1.4 The nursing task must be one that a reasonable and prudent nurse would determine to be a task that may be delegated within the scope of nursing judgment, and include such components as:

a) the task does not require support staff to exercise nursing judgment;
b) the results of the nursing task are reasonably predictable;
c) the nursing task can be safely performed according to exact, unchanging directions, with no need to alter the standard procedures for performing the task; and,
d) the task can be properly and safely performed by the support staff without jeopardizing the welfare of the person with disabilities.

1.5 Support staff shall have documented skill competencies necessary for the proper performance of the task; prior to delegation, the Professional Nurse (R.N.) shall evaluate the support staff person's competency to perform the nursing task.

1.6 The Professional Nurse (R.N.) shall supervise the performance of the delegated nursing activity in accordance with the requirements of supervision. These shall include, but not be limited to, initial direction, periodic evaluation of staff performance, and periodic evaluation of the degree to which the expected outcomes have been achieved.

1.7 The Professional Nurse (R.N.) retains the responsibility and accountability for the delegated task; therefore, if in the nurse's judgment a task cannot be safely delegated, the nurse shall have the authority to decide that the task shall not be delegated and shall document, in writing and in a timely manner, that she/he has informed her/his supervisor of this fact, and the steps that have been taken to ensure that the health and safety of the person with developmental disabilities has not been compromised. If a nurse makes a decision not to delegate a specific task, the nurse must document the rationale for this decision according to the Nursing Clinical Standards outlined herein (*Section NCS 1*).

At no time shall a person with developmental disabilities be placed in a situation in which her/his health and safety needs are not being met because of a delegation refusal and/or dispute.

Technical assistance in the resolution of nursing delegation disputes will be provided by the Office of Health Care/DDD upon request.

NCS 2 NURSING CLINICAL STANDARDS FOR INSTRUCTION TO PREPARE SUPPORT STAFF TO PERFORM PROCEDURES INCLUDING MEDICATION ADMINISTRATION AND TREATMENTS

2.1 The Professional Nurse (R.N.) in conjunction with the agency Administration and Clinical Team, where applicable, shall be responsible for developing and implementing policies and procedures regarding medication administration, treatments, and nursing protocols.

2.2 Support staff shall receive instruction from the Professional Nurse (R.N.) in the following areas prior to the delegation of any nursing tasks, including the administration of medication :

2.2.1 How to perform the procedure including demonstration of the task as appropriate, and safety/infection control measures to be observed;

2.2.2 Indications for the procedure or task to be carried out;

2.2.3 Anticipated outcome, effect, or action;

2.2.4 Contraindications to performing the procedure or task;

2.2.5 Complications, side effects or untoward effects; and,

2.2.6 When and how to report unanticipated events such as contraindications or complications.

2.2.7 The agency's written policy and procedure for medication administration, including protocols for contacting the agency nurse in the event of a medication error and/or medication reaction.

2.2.8 The agency's written policy regarding nursing support protocols for evening, weekend, and holiday coverage.

2.2.9 The agency's written policy and procedure for tube feedings: tube feedings shall be delegated only to support staff who have received documented training for performing this procedure and have displayed appropriate competencies to carry out said procedure. The agency shall have a written policy and procedure which describes the protocol for support staff to follow should a complication or untoward effect arise during or after the procedure.

2.2.10 The agency's written policy and procedure for care of tracheostomies. It shall be at the sole discretion of the Professional Nurse (R.N.) to determine if care of a stable tracheostomy may be delegated, and to whom it may be delegated. The decision shall be made on a case by case basis and shall follow the Nursing Clinical Standards for delegation outlined herein (*Section NCS 1*).

Care of a stable tracheostomy shall be delegated only to support staff who have received documented training for performing this procedure and have displayed appropriate competencies to carry out said procedure. The agency shall have a written policy and procedure which describes the protocol for support staff to follow should a complication or untoward effect arise during or after the procedure.

2.2.11 The agency's written policy and procedure for recording prescription medications and treatments administered per written orders via prescription or inter-agency referral from a physician or other licensed health care provider. All such orders shall be reviewed and countersigned by the Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) in a timely manner.

2.2.12 The agency's written policy and procedure for the implementation of PRN orders for Oxygen (O_2) Therapy. Support staff shall receive specific training in the signs and symptoms of respiratory distress and parameters for notification of the agency nurse. Support staff shall also receive training in emergency procedures to be followed for acute respiratory distress. The initiation of Oxygen (O_2) Therapy shall be delegated only to support staff who have received documented training for performing this procedure and have displayed appropriate competencies to carry out said procedure in accordance with the agency's protocols.

2.2.13 The agency's written policies for the process to be followed for health care communication with family members and/or legal guardians regarding significant changes in medication and/or medical status of the person with developmental disabilities.

2.3 Based upon these Nursing Clinical Standards, the Professional Nurse (R.N.) shall assess the person with developmental disabilities' health care needs including the clinical acuity level and the chronicity of the person's condition. The R.N. shall also assess the health care skill proficiency level of the support staff involved in the person's care. The decision to delegate should be based on an assessment of the support staff person's abilities as well as the medical status of the person with developmental disabilities.

NCS 3 NURSING CLINICAL STANDARDS FOR ACTIVITIES THAT MAY NOT BE DELEGATED

3.1 By way of example, and not in limitation, the following are nursing activities that are solely within the scope of nursing practice and cannot be delegated to support staff:

3.1.1 Any part of the nursing process, including nursing activities which require nursing assessment/data collection; nursing diagnosis; planning; intervention; and evaluation. Nursing activities, procedures, and interventions which require an understanding of nursing process or nursing assessment and judgment during implementation are licensed procedures.

3.1.2 Physical, psychological, and social assessment which requires nursing judgment, intervention, referral or follow-up. However, in cases of accident, emergency or the acute onset of serious illness, support staff shall be authorized to call 911 or transport the person to the Emergency Room for evaluation and treatment, while following the agency's written policy and procedure for Emergency Room transport and notification of the agency nurse**.**

3.1.3 Formulation of a nursing plan of care and evaluation of the person with developmental disabilities' response to the care provided.

3.1.4 Receiving or transmitting verbal or telephone orders from physicians or other licensed health care providers.

3.1.5 Wound care, including but not limited to:
a) complex sterile dressings beyond the parameters of simple wound care;
b) dressings to a central line; and,
c) irrigation, packing or sterile procedures such as cleansing or dressing penetrating wounds or deep burns.

3.1.6 Any invasive procedures, including but not limited to:
a) insertion or re-insertion of a foley catheter, supra-pubic tube, or any other type of catheter or tube;
b) irrigation of a foley catheter, supra-pubic tube, or any other type of catheter or tube;
c) re-insertion of a gastrostomy tube or tracheostomy tube; and/or,
d) removal of tubes or other foreign materials.

3.1.7 Documented evaluation and assessment by the Professional Nurse (R.N.) prior to the implementation of tube feedings or care of a stable tracheostomy.

3.1.8 Documented evaluation and assessment by the Professional Nurse (R.N.) prior to the implementation of oral suctioning.

3.1.9 Deep suctioning of a person with or without a tracheostomy.

3.1.10 Intravenous (IV) therapy, including but not limited to:[3]
a) starting or re-starting IV's;
b) assessment and evaluation of the IV site;
c) dressing changes to the site;
d) administration of medications through the IV;
e) hanging/changing the IV solution bag;
f) removal of any portion of the IV set-up; and,
g) phlebotomy

3.1.11 Assessment for Administration of Oxygen (O_2) Therapy
The Professional Nurse (R.N.) shall perform an assessment of the person to be receiving O_2 therapy, and document the physician's or other licensed health care provider's O_2 order in the person's plan of care. The plan of care shall include, but not be limited to a) the parameters for initiating O_2 therapy;
b) the flow rate as indicated in the written order;
c) signs and symptoms of respiratory distress; and,
d) safety precautions for support staff to follow while O_2 is being utilized.

3.1.12 Interpretation of pulse oximetry for a person receiving Oxygen (O_2) Therapy.

3.1.13 Tasks related to the administration of medication:
a) calculation of any medication dosages;
b) change in any medication dosage; and,
c) administration of any medications by injectable route including insulin.

[3] (a) Starting or re-starting IV's, (d) administration of medications through the IV, and (g) phlebotomy, are within the scope of practice of Registered Nurses (R.N.'s) only and may not be delegated to Licensed Practical Nurses (L.P.N.'s).

APPENDICES

Appendix A — *RI Nurse Practice Act* (Chapter 5-34 of the R.I. General Laws, as amended) and *RI Rules and Regulations for the Licensing of Nurses*

Appendix B — *Controlled Medication Formulary*

Appendix C — Summary of Immunization Recommendations from *The Advisory Council on Immunization Practices (ACIP) Guidelines*

Appendix D — National Fire Protection Association's *Oxygen Storage Requirements*

Appendix E — *Legend Drugs*/Title 21 Food and Drugs/Chapter 21-31, Rhode Island Food, Drugs, and Cosmetics Act (Section 21-31-15 of the R.I. General Laws);

Procedure for Disposing of Controlled Substances; (Drug Enforcement Administration, Department of Justice. Title 21 CFR Part 1307.21, April 1, 1996 edition)

*Controlled Substances/*Title 21 Food and Drugs Chapter 21-28 Uniform Controlled Substances Act (Article 21-28-1.01 Section 21-28-1.02 and Article 21-28-5.01 Section 21-28-5.07 of the R.I. General Laws)

Appendix F — *Rules and Regulations Governing the Disposal of Legend Drugs* (RI Department of Health, as amended March 1998).

Appendix G — *Baseline Competency Training Checklist* and *Nursing Delegation Procedure Performance Evaluation*